ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

Schedule D-1

| Provider Name | Medicaid Provider Number | Reporting Period<br>From: Through: |
|---|---|---|
| | | |

All ICFs-MR need only use group (A).

NFs that did not change provider agreement on or after 7/01/93 need only use group (A).

NFs that did change provider agreement on or after 7/01/93 use groups (A) and (B).

GROUP A ASSETS ACQUIRED

| | ACCOUNT | Date Acquired (1) | Cost at Beginning of Period (2) | Additions or Reductions (3) | Cost at End of Period [Col 2 + Col 3] (4) | Accumulated Depreciation End of Period (5) | Net Book Value End of Period (Col 4 - Col 5) (6) | Depreciation this Period (7) |
|---|---|---|---|---|---|---|---|---|
| 1. | Land | | | | | | | |
| 2. | Buildings | | | | | | | |
| 3. | Land Improvements | | | | | | | |
| 4. | Leasehold Improvements | | | | | | | |
| 5. | Equipment | | | | | | | |
| 6. | Transportation | | | | | | | |
| 7. | Financing Costs | | | | | | | |
| 8. | TOTAL | | | | | | | |

Has there been any change in the original historical cost of capital assets? YES ☐ NO ☐

If yes, submit complete detail.

GROUP A RENOVATIONS

Complete for renovations in use during cost report period reimbursable under OAC Rules 5101:3-3-51 and 5101:3-3-84.

| | Cost at Beginning of Period (1) | Additions or Reductions (2) | Project Cost End of Period (Col 2 + Col 3) (3) | Accumulated Depreciation End of Period (4) | Net Book Value End of Period [Col 4 - Col 5] (5) | Depreciation/ Amortization this Period (6) | Interest this Period (7) | Total Columns 6 and 7 (8)** |
|---|---|---|---|---|---|---|---|---|
| 9. | | | | | | | | |
| 10. | TOTAL | | | | | | | |

** Transfer TOTAL of column 8 to Schedule D, column 3, line 12.

GROUP B ASSETS ACQUIRED THROUGH A CHANNGE OF PROVIDER AGREEMENT

NFs, other than leased facilities, that changed Provider Agreement on or after 7/01/93 use this group to report expenses incurred through a change of of provider agreement on or after 7/01/93.

| | ACCOUNT | Date Acquired (1) | Cost at Beginning of Period (2) | Additions or Reductions (3) | Cost at End of Period [Col 2 + Col 3] (4) | Accumulated Depreciation End of Period (5) | Net Book Value End of Period (Col 4 - Col 5) (6) | Depreciation this Period (7) |
|---|---|---|---|---|---|---|---|---|
| 11. | Land | | | | | | | |
| 12. | Buildings | | | | | | | |
| 13. | Equipment | | | | | | | |
| 14. | Financing Costs | | | | | | | |
| 15. | TOTAL | | | | | | | |

Has there been any change in the original historical cost of capital assets? YES ☐ NO ☐

If yes, submit complete detail.



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**CAPITAL ADDITIONS AND / OR DELETIONS**

Schedule D-2

| Provider Name | Medicaid Provider Number | Reporting Period<br>From: Through: |
|---|---|---|

Columns 12 and 13 are mandatory only in the event of an asset deletion.
Completion of this schedule is optional if the detailed depreciation schedule submitted includes all criteria noted in D-2 except for columns 8 and 11.

| Asset Description (1) | Asset Account Title (2) | Date Acquired MM/DD/YY (3) | Date Disposed MM/DD/YY (4) | Method of Deprec. (5) | Acquisition Cost (6) | Useful Life (7) | Annual Depreciation (8) | Depreciation for C/R Period (9) | C/R Period Ending Accum Depreciation (10) | Net Book Value (11) | Sales Price (12) | Gain or (Loss) on disposal (13) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
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| | | | | | | | | | | | | |
| TOTAL | | | | | | | | | | | | |

* Columns 6, 9, 10, and 11 should tie to Schedule D-1 sum of Renovations and Cost of Ownership for each column.

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BALANCE SHEET

Schedule E

| Provider Name | Medicaid Provider Number | Reporting Period From: Through: |
|---|---|---|

| | | Chart of Acct. No. | BALANCE PER BOOKS | |
|---|---|---|---|---|
| | **CURRENT ASSETS** | | Beginning of Period | End of Period |
| 1 | Petty Cash | 1001 | | |
| 2 | Cash In Banks - General Account | 1010 | | |
| 3 | Accounts Receivable | 1030 | | |
| 4 | Allowance For Uncollectible Accounts | 1040 | | |
| 5 | Notes Receivable | 1050 | | |
| 6 | Allowance For Uncollectible Notes Receivable | 1060 | | |
| 7 | Other Receivables | 1070 | | |
| 8 | Cost Settlement | 1080 | | |
| 9 | Inventories | 1090 | | |
| 10 | Prepaid Expenses | 1100 | | |
| 11 | Short-Term Investments | 1110 | | |
| 12 | Special Expenses | 1120 | | |
| 13 | Total Current (sum of lines 1 through 12) | | | |
| | **PROPERTY, PLANT AND EQUIPMENT** | | | |
| 14 | Property, Plant & Equipment | 1200 | | |
| 15 | Accumulated Depreciation And Amortization | 1250 | | |
| 16 | Renovations | 1300 | | |
| 17 | Accumulated Depreciation And Amortization - Renovations | 1350 | | |
| 18 | Total Property, Plant & Equipment (sum of lines 14 through 17) | | | |
| | **OTHER ASSETS** | | | |
| 19 | Non-Current Investments | 1400 | | |
| 20 | Deposits | 1410 | | |
| 21 | Due From Owners / Officers ( to Sch. E-1, pg. 1 of 2, line 2 ) | 1420 | | |
| 22 | Deferred Charges And Other Assets | 1430 | | |
| 23 | Notes Receivable - Long-Term | 1440 | | |
| 24 | Total Other Assets (sum of lines 19 through 23) | | | |
| 25 | Total Assets (sum of lines 13, 18 and 24) | | | |
| | **CURRENT LIABILITIES (Report credit balances as positive amounts)** | | | |
| 26 | Accounts Payable | 2010 | | |
| 27 | Cost Settlements | 2020 | | |
| 28 | Notes Payable | 2030 | | |
| 29 | Current Portion Of Long-Term Debt | 2040 | | |
| 30 | Accrued Compensation | 2050 | | |
| 31 | Payroll Related Withholding and Liabilities | 2060 | | |
| 32 | Taxes Payable | 2080 | | |
| 33 | Other Liabilities, specify; | 2090 | | |
| 34 | Total Current Liabilities (sum of lines 26 through 33) | | | |
| | **LONG-TERM LIABILITIES (Report credit balances as positive amounts)** | | | |
| 35 | Long-Term Debt | 2410 | | |
| 36 | Related Party Loans - Interest Allowable | 2420 | | |
| 37 | Related Party Loans - Interest Non-Allowable ( To Sch E-1, pg 1 of 2, line 3 ) | 2430 | | |
| 38 | Non-Interest Bearing Loans From Owners ( to Sch. E-1, pg 1 of 2, line 4 ) | 2440 | | |
| 39 | Deferred Liabilities | 2450 | | |
| 40 | Total Long-Term Liabilities (sum of lines 35 through 39) | | | |
| 41 | Total Liabilities (sum of lines 34 and 40) | | | |
| 42 | Capital line 25 less line 41 (to Sch. E-1, pg. 1 of 2, line 1) | 3000 | | |
| 43 | **TOTAL LIABILITIES AND CAPITAL (must equal line 25)** | | | |



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Schedule E-1
1 of 2

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

| Provider Name: | Medicaid Provider Number | Reporting Period From: Through: |
|---|---|---|

| | REIMBURSABLE EQUITY | BALANCE PER BOOKS Beginning of Period (1) | End of Period (2) |
|---|---|---|---|
| 1 | Capital (from Sch. E, line 42) | | |
| 2 | Due From Owners/Officers ( from Sch. E, line 21 ) | ( ) | ( ) |
| 3 | Related Party Loans - Interest Non-Allowable ( from Sch. E, line 37 ) | | |
| 4 | Non-Interest Bearing Loans From Related Party ( from Sch. E, line 38 ) | | |
| 5 | Equity In Assets Leased From Related Party (attach detail) | | |
| 6 | Home Office Equity (attach detail) | | |
| 7 | Cash Surrender Value of Life Insurance Policy | ( ) | ( ) |
| 8 | Other, Specify | | |
| 9 | Other, Specify | | |
| 10 | Other, Specify | | |
| 11 | Other, Specify | | |
| 12 | Other, Specify | | |
| 13 | Other, Specify | | |
| 14 | Other, Specify | | |
| 15 | Other, Specify | | |
| 16 | Other, Specify | | |
| 17 | Other, Specify | | |
| 18 | Other, Specify | | |
| 19 | Other, Specify | | |
| 20 | Other, Specify | | |
| 21 | Other, Specify | | |
| 22 | **Total Reimbursable Equity** (column 1 to E-1, page 2 of 2, line 23, column 2) (column 2 to E-1, page 2 of 2, line 34, column 8) | | |

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Schedule E-1
2 of 2

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

| Name of Provider | Medicaid Provider Number | Reporting Period From: Through: |
|---|---|---|

| Month (1) | Reimbursable Equity Beginning of Period (2) | Capital Investments During Period (3) | Gain (Loss) On Disposal of Assets (4) | Withdrawals, or Dividend Distribution (5) | Other Increase / (Decrease) (6) | Increases or (decreases) due to Operations (7) | Reimbursable Equity Capital End of Month (net total of columns 2-7) (8) * |
|---|---|---|---|---|---|---|---|
| 23 January | | | | ( ) | | | |
| 24 February | | | | ( ) | | | |
| 25 March | | | | ( ) | | | |
| 26 April | | | | ( ) | | | |
| 27 May | | | | ( ) | | | |
| 28 June | | | | ( ) | | | |
| 29 July | | | | ( ) | | | |
| 30 August | | | | ( ) | | | |
| 31 September | | | | ( ) | | | |
| 32 October | | | | ( ) | | | |
| 33 November | | | | ( ) | | | |
| 34 December | | | | ( ) | | | |
| 35 **Total** | | | | | | | |

| | 1 | | 2 | | 3 | | 4 | | 5 ** |
|---|---|---|---|---|---|---|---|---|---|
| 36 Return on Equity | _____ | / | _____ | X | _____ | / | _____ | = | _____ (Ref. Sch. A-3, line 12 col. 5) |

* **Column # 8 – If the result in Column 8, lines 23 - 34, is a negative figure, enter "0" on lines 23 - 34. Do not enter less than zero.**

** **Maximum Return on Equity is $1.00 (see instructions)**

INSTRUCTIONS FOR COMPLETING LINE NUMBER 36

Column # 1 Enter amount from Schedule E-1 line 35 column 8.
Column # 2 Enter number of months in reporting period.
Column # 3 Enter Rate of Return Ratio, use 4 decimal places to the right of the decimal.
Column # 4 Enter allowable capital days from Schedule A line 6.2 column 1.
Column # 5 Enter result of the previous calculations or $1.00, whichever is less.



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REVENUE TRIAL BALANCE

| Provider Name | Medicaid Provider Number | Reporting Period From: | Through: |
|---|---|---|---|

| | REVENUE ACCOUNT NAME | | Chart of Account (1) | Total (2) | Adjustments Increase (Decrease) (3) | Adjusted Total (Col. 2 + Col. 3) (4) |
|---|---|---|---|---|---|---|
| | **ROUTINE SERVICE - ROOM AND BOARD** | | | | | |
| 1 | Private | | 5010 | | | |
| 2 | Medicare | | 5011 | | | |
| 3 | Medicaid | | 5012 | | | |
| 4 | Veterans | | 5013 | | | |
| 5 | Other | | 5014 | | | |
| 6 | TOTAL (lines 1 through 5) | | | | | |
| | **DEDUCTIONS FROM REVENUES** | | | | | |
| 7 | Contractual Allowance-Medicare | | 5710 | | | |
| 8 | Contractual Allowance-Medicaid | | 5720 | | | |
| 9 | Contractual Allowance-Other | | 5730 | | | |
| 10 | Charity Allowance | | 5740 | | | |
| 11 | TOTAL (lines 7 through 10) | | | | | |
| | **THERAPY SERVICES** | | | | | |
| 12 | Physical Therapy | | 5020 | | | |
| 13 | Occupational Therapy | | 5030 | | | |
| 14 | Speech Therapy | | 5040 | | | |
| 15 | Audiology Therapy | | 5050 | | | |
| 16 | Respiratory Therapy | | 5060 | | | |
| 17 | TOTAL (lines 12 through 16) | | | | | |
| | **MEDICAL SUPPLIES** | | | | | |
| 18 | Medicare B - Medicaid | To Sch. A-2, Line 1a, Col. 2 | 5070-1 | | | |
| 19 | Medicare B - Other | To Sch. A-2, Line 1a, Col. 3 | 5070-2 | | | |
| 20 | Private | To Sch. A-2, Line 1a, Col. 4 | 5070-3 | | | |
| 21 | Medicare A | To Sch. A-2, Line 1a, Col. 5 | 5070-4 | | | |
| 22 | Veterans | To Sch. A-2, Line 1a, Col. 6 | 5070-5 | | | |
| 23 | Other | To Sch. A-2, Line 1a, Col. 6 | 5070-6 | | | |
| 24 | Medicaid | To Sch. A-2, Line 1a, Col. 7 | 5070-7 | | | |
| 25 | Medical Supplies - Routine | | 5080 | | | |
| 26 | TOTAL (lines 18 through 25) | | | | | |
| | **MEDICAL MINOR EQUIPMENT** | | | | | |
| 27 | Medicare B - Medicaid | To Sch. A-2, Line 2a, Col. 2 | 5090-1 | | | |
| 28 | Medicare B - Other | To Sch. A-2, Line 2a, Col. 3 | 5090-2 | | | |
| 29 | Private | To Sch. A-2, Line 2a, Col. 4 | 5090-3 | | | |
| 30 | Medicare A | To Sch. A-2, Line 2a, Col. 5 | 5090-4 | | | |
| 31 | Veterans | To Sch. A-2, Line 2a, Col. 6 | 5090-5 | | | |
| 32 | Other | To Sch. A-2, Line 2a, Col. 6 | 5090-6 | | | |
| 33 | Medicaid | To Sch. A-2, Line 2a, Col. 7 | 5090-7 | | | |
| 34 | Medical Minor Equipment - Routine | | 5100 | | | |
| 35 | TOTAL (lines 27 through 34 ) | | | | | |



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REVENUE TRIAL BALANCE

| Provider Name | Medicaid Provider Number | Reporting Period From: | Through: |
|---|---|---|---|
| | | | |

| | REVENUE ACCOUNT NAME | | Chart of Account (1) | Total (2) | Adjustments Increase (Decrease) (3) | Adjusted Total (Col. 2 + Col. 3) (4) |
|---|---|---|---|---|---|---|
| | **ENTERAL NUTRITION THERAPY** | | | | | |
| 36 | Medicare B - Medicaid | To Sch. A-2, Line 3a, Col. 2 | 5110-1 | | | |
| 37 | Medicare B - Other | To Sch. A-2, Line 3a, Col. 3 | 5110-2 | | | |
| 38 | Private | To Sch. A-2, Line 3a, Col. 4 | 5110-3 | | | |
| 39 | Medicare A | To Sch. A-2, Line 3a, Col. 5 | 5110-4 | | | |
| 40 | Veterans | To Sch. A-2, Line 3a, Col. 6 | 5110-5 | | | |
| 41 | Other | To Sch. A-2, Line 3a, Col. 6 | 5110-6 | | | |
| 42 | Medicaid | To Sch. A-2, Line 3a, Col. 7 | 5110-7 | | | |
| 43 | Enteral Nutrition Therapy - Routine | | 5120 | | | |
| 44 | **TOTAL (lines 36 through 43)** | | | | | |
| | **OTHER ANCILLARY SERVICE** | | | | | |
| 45 | Habilitation Supplies | | 5130 | | | |
| 46 | Incontinence Supply | | 5140 | | | |
| 47 | Personal Care | | 5150 | | | |
| 48 | Laundry Service - Routine | | 5160 | | | |
| 49 | **TOTAL (lines 45 through 48)** | | | | | |
| | **OTHER SERVICES** | | | | | |
| 50 | Dry Cleaning Service | | 5310 | | | |
| 51 | Communications | | 5320 | | | |
| 52 | Meals | | 5330 | | | |
| 53 | Barber And Beauty | | 5340 | | | |
| 54 | Personal Purchases - Residents | | 5350 | | | |
| 55 | Radiology | | 5360 | | | |
| 56 | Laboratory | | 5370 | | | |
| 57 | Oxygen | | 5380 | | | |
| 58 | Legend Drugs | | 5390 | | | |
| 59 | Other - Specify below | | 5400 | | | |
| 60 | **TOTAL (lines 50 through 59)** | | | | | |

Line 59 Other - Specify below

| Account Title | Amount |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| **Total must tie to line 59, col. 2** | |



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REVENUE TRIAL BALANCE

| Provider Name | Medicaid Provider Number | Reporting Period From: | Through: |
|---|---|---|---|
| | | | |

| | REVENUE ACCOUNT NAME | Chart of Account (1) | Total (2) | Adjustments Increase (Decrease) (3) | Adjusted Total (Col. 2 + Col. 3) (4) |
|---|---|---|---|---|---|
| | **NON-OPERATING** | | | | |
| 61 | Management Services | 5510 | | | |
| 62 | Cash Discounts | 5520 | | | |
| 63 | Rebates And Refunds | 5530 | | | |
| 64 | Gift Shop | 5540 | | | |
| 65 | Vending Machine Revenues | 5550 | | | |
| 66 | Vending Machine Commissions | 5555 | | | |
| 67 | Rental - Space | 5560 | | | |
| 68 | Rental - Equipment | 5570 | | | |
| 69 | Rental - Other | 5580 | | | |
| 70 | Interest Income - Working Capital | 5590 | | | |
| 71 | Interest Income - Restricted Funds | 5600 | | | |
| 72 | Interest Income - Funded Depreciation | 5610 | | | |
| 73 | Interest Income - Related Party Revenue | 5620 | | | |
| 74 | Interest Income - Contributions | 5625 | | | |
| 75 | Endowments | 5630 | | | |
| 76 | Gain/Loss On Disposal Of Assets | 5640 | | | |
| 77 | Gain/Loss On Sale Of Investments | 5650 | | | |
| 78 | Nurse Aide Training Program Revenue | 5660 | | | |
| 79 | Unrestricted Contributions | 5670 | | | |
| 80 | **TOTAL (lines 61 through 79)** | | | | |
| 81 | **TOTAL (Sum of Lines 6, 11, 17, 26, 35, 44, 49, 60, and 80)** | | | | |



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ADJUSTMENT TO TRIAL BALANCE

| Name of Facility | Medicaid Provider Number | Reporting Period<br>From: Through: |
|---|---|---|

| Line # | Description | Revenue Chart of Account # (1) | Salary Increase (Decrease) (2) | Other Increase (Decrease) (3) | Total Increase (Decrease) (Col. 2 + Col. 3) (4) | Expense Chart of Account # (5) | Revenue Reference Attachment 1 Line (6) |
|---|---|---|---|---|---|---|---|
| 1. | Meals | 5330 | | | | | 52 |
| 2. | Barber and Beauty | 5340 | | | | | 53 |
| 3. | Vending Machine Revenues | 5550 | | | | | 65 |
| 4. | Interest Income - Working Capital | 5590 | | | | | 70 |
| 5. | Nurse Aide Training Program Revenue | 5660 | | | | | 78 |
| 6. | Miscellaneous Inc., Specify: | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |
| 9. | | | | | | | |
| 10. | | | | | | | |
| 11. | | | | | | | |
| 12. | | | | | | | |
| 13. | TOTAL | | | | | | |



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Attachment 3

MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

| Provider Name | Medicaid Provider Number | Reporting Period<br>From: Through: |
|---|---|---|

As per the Cost Report instructions, any documentation required by the Department, or needed to clarify individual line items (or groupings) must be submitted as hard copy and labeled as an Exhibit. To facilitate the reporting and review process of this submitted Cost Report (including Exhibits) the Department requires that Exhibits 1 through 4 shall be standardized according to the following criteria. Exhibits 1 and 2 are required and will be labeled accordingly. Exhibits 3 and 4, if needed, will also be labeled accordingly. In certain situations, if Exhibits 3 and 4 are not applicable the corresponding Exhibit number shall not be used. Any other additional Exhibit attached will be labeled by number (beginning with 5). Exhibits 1 through 4 are reserved for the specific items as listed below.

**Please attach one copy of the following:**

Exhibit 1. Facility trial balance that detail the general ledger account names as of December 31, 20CY.

IF THE RECOMMENDED CHART OF ACCOUNTS PER OAC 5101 3-3-201 IS NOT USED, IT IS THE RESPONSIBILITY OF THE PROVIDER TO RELATE ITS CHART OF ACCOUNTS DIRECTLY TO THE COST REPORT. (One copy with each cost report is required.)

Exhibit 2. Complete and detailed depreciation schedules in a format as defined on schedule D-2 of this cost report. (One copy with each cost report is required.)

Exhibit 3. Home office trial balances and the allocation work sheets that are required to show how the home office trial balance is allocated to each individual facility's cost report. Include: Account groupings for each home office account. The allocation procedures are pursuant to HCFA 15-1 Chapter 21, section 2150 through section 2153. (If applicable - One copy with each Cost Report is required.)

Exhibit 4. Copies of the Franchise Tax forms to support any Franchise Taxes reported. (If applicable - One copy with each Cost Report is required.)

Exhibit 5. Any other documentation which you feel is necessary to explain your cost(s). You must identify exhibits with cross references to applicable schedule and line number or item, example: Exhibit 5 references schedule C, line 8, col. 4.

Failure to cross-reference exhibits, to the applicable Cost Report schedule, line, and column, may qualify this report as being incomplete. Incomplete filings can result in penalties applied pursuant to OAC Rule 5101:3-3-20.

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